PATIENT INFORMATION (Please Print)

Date_____

Patient Name_____

Birthdate_____ Age_____ Sex☐ **M** ☐ **F** SS Number_____

Street Address_____

City_____ State_____ Zipcode_____

Parent/Guardian address (if different) _____

Phone #_____ Cell #_____

Email _____

How were you referred to or find us? _____

EMERGENCY CONTACT

Name_____ Relationship_____

Phone #_____ Cell #_____

INSURANCE INFORMATION

Insurance Company_____ Phone #_____

ID #_____ Group #_____

Subscriber Name (if different from Patient)_____

Subscriber Birthdate_____ SS Number_____ Relationship_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the above named Insurance Company and assign directly to Dr. Dental all insurance benefits, if any, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named medical facility may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This consent will stay in effect as long as I am a patient with the above named medical facility.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative

Please Print Name of Signature of Patient, Parent, Guardian or Personal Representative

_____ _____

Date

Relationship to Patient

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HEALTH HISTORY

Patient (printed) name _____ DOB: _____

Please circle "yes or no" to indicate if you have, or have had any of the following:

AIDS/HIV	Yes	No	Epilepsy	Yes	No	Respiratory Disease	Yes	No
Anemia	Yes	No	Fainting or Dizziness	Yes	No	Rheumatic Fever	Yes	No
Arthritis	Yes	No	Glaucoma	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valves	Yes	No	Headaches	Yes	No	Shortness of breath	Yes	No
Artificial Joints	Yes	No	Heart Murmur	Yes	No	Sinus Trouble	Yes	No
Asthma	Yes	No	Heart Problems	Yes	No	Skin Rash	Yes	No
Back Problems	Yes	No	Hepatitis Type_____	Yes	No	Special Diet	Yes	No
Bleeding Abnormally	Yes	No	Herpes	Yes	No	Stroke	Yes	No
Blood Disease	Yes	No	High Blood Pressure	Yes	No	Swollen Feet/Ankles	Yes	No
Cancer	Yes	No	Jaundice	Yes	No	Swollen Neck/Glands	Yes	No
Chemical Dependency	Yes	No	Jaw Pain	Yes	No	Thyroid Problems	Yes	No
Chemotherapy	Yes	No	Liver Disease	Yes	No	Tonsillitis	Yes	No
Circulatory Problems	Yes	No	Low Blood Pressure	Yes	No	Tuberculosis	Yes	No
Congenital Heart Lesion	Yes	No	Mitral Valve Prolapse	Yes	No	Tumors	Yes	No
Cortisone Treatments	Yes	No	Nervous Problems	Yes	No	Ulcer	Yes	No
Cough, Persistant,Bloody	Yes	No	Pacemaker	Yes	No	Venereal Disease	Yes	No
Diabetes	Yes	No	Psychiatric Care	Yes	No	Weight Loss, severe	Yes	No
Emphysema	Yes	No	Radiation Treatment	Yes	No			

Do you wear contact lenses? Yes No

Taking Birth Control? Yes No

Are you pregnant? Yes No Due date_____ Are you nursing? Yes No

Physician's Name and Phone Number_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin, (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine) **Yes No**

MEDICATIONS

List any medications you are currently taking.

_____

_____

_____

_____

_____

ALLERGIES

Circle allergies to listed, or others not listed.

Aspirin Latex

Barbiturates (sleeping pills)

Codeine Local Anesthetic

Iodine Penicillin

Other_____

Patient signature_____ **Date**_____

Doctors Signature_____ **Date**_____

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GENERAL CONSENT

Please read this form carefully. Should you have any questions, our staff will be happy to help you.

1.) I hereby authorize and direct the dentist and/or dental auxiliaries to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.

2.) I understand x-rays, photographs, models of the mouth, and/or other diagnostic aids used for an accurate diagnosis and treatment planning are the property of the doctors but copies of certain aids are available upon request for a fee.

3.) In general terms, the dental procedure(s) can include but not limited to:

- **A.** Comprehensive oral examination, radiographs, cleaning of the teeth, and the application of topical fluoride.
- **B.** Application of resin "sealants" to the grooves of the teeth.
- **C.** Treatment of diseased, or injured teeth with dental restorations (fillings).
- **D.** Treatment of diseased or injured oral tissue secondary to traumatic injuries and/or accidents and/or Infections

4.) I understand that the doctor is not responsible for previous dental treatment performed in other offices. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement. I realize that guarantees of results or absolute satisfaction are not always possible in dental health service.

5.) I certify that if I, and/or my dependents have insurance coverage I assign directly to the dentist all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

6.) I have answered all of the questions about me or my dependent's medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all medical conditions, including allergies. I also understand if my dependent or I ever have any changes in health status or any changes in medication(s), I will inform the doctor at the next appointment.

I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner and I believe I have sufficient information to give this informed consent. I further understand that this consent shall remain in effect until terminated by me.

_____	_____
PATIENT NAME	DATE OF BIRTH
_____	_____
PARENT/GUARDIAN IF PATIENT IS A MINOR	RELATIONSHIP TO PATIENT
_____	_____
SIGNATURE	DATE

INFORMED CONSENT FORM

1. Drugs and Medications:

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction)…… (Initials _____)

2. Changes In Treatment Plan:

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary once they've been discovered and discussed …… (Initials _____)

3. Removal Of Teeth:

Alternatives to removal will be explained to me (root canal therapy, crowns, dentures and periodontal surgery, etc.) and I will have the choice of the best procedure for me. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time (days or months), or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility…… (Initials _____)

4. Crowns and Bridges:

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown/bridge (including shape, fit, size, color) will be before cementation …….. (Initials _____)

5. Endodontic Treatment (Root Canal Therapy):

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy)…… (Initials _____)

6. Periodontal Loss (Tissue & Bone):

I understand that periodontal disease is a serious condition, causing gum and bone infection or loss and that it can lead to loss of my teeth. Alternative treatment plans will be explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition…… (Initials _____)

7. X-Rays:

I understand x-rays are needed for proper diagnosis and treatment…… (Initials _____)

8. Dentures, Complete or Partials:

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems with wearing these appliances has been explained to me, including, looseness, soreness and possible breakage. I realize the final opportunity to make changes to my new dentures (including, shape, fit, size, placement & color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for these procedures are not included in the initial denture fees. I understand wearing dentures is difficult & there are common problems such as sore spots, altered speech & difficulty eating. Immediate dentures (placement of dentures immediately after extractions) may be painful, will require considerable adjustments & several relines and a permanent reline will be needed later; this is NOT included in the denture fee. It is important to make all necessary impression, try-in & delivery appointments, failure to make these appointments can result in poorly fitting dentures and the need to remake them, resulting in additional charges…… (Initials _____)

9. Fillings:

I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more expensive filling may be required due to additional decay than what could be seen by the x-ray and that significant sensitivity is a common after effect of a newly place filling …… (Initials _____)

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

_____

Printed Name of Patient Date

_____

Patient Signature

_____

Signature of Parent/Guardian if patient is a minor

_____

Doctor's Signature Date

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PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the **"Notice of Privacy Practices"** and have been provided an opportunity to review it.

Patient_____ Birthdate_____

Parent/Guardian_____

Signature_____ Date_____